Maryland HealthChoice Demonstration
Section 1115 Quarterly Report
Demonstration Year 20 (January 1, 2017, through December 31, 2017)
Federal Fiscal Quarter 3 (1/1/2017 – 3/31/2017)

Introduction

The HealthChoice section 1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to the beneficiary's specific medical needs. Now in its twentieth waiver year, Maryland implemented the HealthChoice program and moved its fee-for-service enrollees into a managed care payment system following approval of the waiver by what is now the Centers for Medicare and Medicaid Services (CMS) in 1996. Under the statewide health care reform program, the state enrolls individuals affected by or eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care, or one of the demonstration's authorized health care programs.

The state's goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP); and
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

Subsequent to the initial grant, Maryland requested and received several program extensions, in 2002, 2005, 2008, 2011 2013, and 2017. The 2017 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) Program as part of a comprehensive SUD strategy;
- Created Community Health Pilot Programs:
    - Evidence-Based Home Visiting (HV) pilot program for high-risk pregnant women and children up to two (s) years of age; and
    - Assistance in Community Services Integration pilot;
- Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and,
- Expanded dental benefits for former foster youth.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current quarters. These counts represent individuals, as opposed to member months.

Table 1. Enrollment Counts

Demonstration Populations	Previous Quarter (as of December 31, 2016)	Current enrollees (as of March 31, 2017)
Parents/Caretaker Relatives <116% FPL and Former Foster Care	208,847	213,674
ACA Expansion Adults	291,044	302,629
Medicaid Children	447,509	458,344
SSI/BD Adults	89,000	88,846
Medically-Needy Adults	22,359	22,218
Medically-Needy Children	5,426	5,605
SOBRA Adults	9,240	9,432
MCHP	114,015	114,370
MCHP Premium	30,953	30,903
Family Planning	9,673	9,470
ICS	25	26
WBCCTP	154	146
PEPW	6	5

Outreach/Innovative Activities

Medicaid and National Diabetes Prevention Program (DPP) grant

During this quarter, the four MCOs participating in the demonstration, Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners, made significant progress in reaching final contracting stage or in executing subcontracts with their identified virtual and community-based DPP Suppliers. Three of the four MCOs began enrollment of beneficiaries into DPPs. As of March 31, 2017, 96 beneficiaries had enrolled in a DPP.

In a presentation on the Medicaid and National DPP demonstration to the Maryland Medicaid Advisory Committee (MMAC) on February 27, 2017, accomplishments to date were presented, including: issued grant announcements to eight MCOs; secured MCO grant agreements with four MCOs and issued a press release; modified budgets and finalized work plans; provided initial data set/contact information to MCOs; developed invoicing and fiscal processes; established project leadership; established billing framework with Common Procedural Terminology (CPT) codes plus modifier & International Classification of Diseases (ICD)-10 codes; achieved departmental Internal Review Board (IRB)

determination and implementation of informed consent; MCOs executed or are currently executing contracts with DPPs; held successful state visit with funder with National Association of Chronic Disease Directors (NACDD), the Center for Disease Control (CDC), and Leavitt Partners (the healthcare consulting company developing a DPP toolkit); and began enrolling Medicaid beneficiaries in DPPs.

Lessons learned thus far include:

- Establishing contracts with DPPs can take longer than expected;
- Incorporating a pay-for-performance model into a coding and billing framework presents a challenge;
- It was necessary to develop guidance around changes in eligibility and health status; and
- Enrollment and retention strategies are a central focus of the MCOs.

Next steps in the project include engaging additional existing National DPP suppliers in Maryland to partner with MCOs; finalizing contracts with DPPs; testing and identifying recruitment and retention methods; seeking a Spanish-language DPP supplier; offering an incentive survey to DPP suppliers; continuing to share in the NACDD learning community; contributing to the toolkit currently under development; monitoring Medicare DPP rulemaking and implementation; and meeting the target of 100 enrollees per MCO by May 31.

Community Health Pilots
The Department continued to work with CMS in negotiating final post-approval protocols for the two Community Health Pilots included in the 1115 HealthChoice Waiver Renewal application: Evidence-based Home-Visiting Services for High-Risk Pregnant Women and Children Up to Age 2 (HVS); and Assistance in Community Integrated Services (ACIS). Updates on the status of the pilots were presented to stakeholders, including local health officers, and posted on the Department's waiver renewal website. Once post-approval protocols are finalized with CMS, the Department will issue a request for Letters of Intent from applicants, including the updated implementation timeline.

Operational/Policy Developments/Issues

As of March 2017, there were eight MCOs participating in the HealthChoice program; their respective market shares are as follows: Amerigroup (24.3 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.0 percent); Maryland Physicians Care (18.8 percent); MedStar Family Choice (7.3 percent); Priority Partners (25.0 percent); University of Maryland Health Partners (3.4 percent); and United Healthcare (14.0 percent).

The MMAC met in January, February, and March of 2017. The following issues were discussed over the course of the three meetings:

- The Department presented on a report on Telehealth released in December 2016. The Department made two main recommendations: (1) expand the providers who can participate in the Medicaid telehealth program; and (2) develop a remote patient monitoring program.

- The Department is working on a system requirement to make a modification to the

Medicaid auto renewals so that they will auto renew every two years. The Department is hoping to implement that in July 2017 prior to open enrollment.

- The Department, in conjunction with the Behavioral Health Administration, is in the process of establishing rates for residential substance use treatment as a part of the Institutions for Mental Diseases (IMD) program. The Department is working to have these new rates be effective by July 1, 2017.

- The Department is actively working with CMS on the post approval process for the 1115 waiver. In parallel, the Department is also working on giving guidance about the community health pilot programs. The Department's goal is to implement these new programs by July 1, 2017.

- The Department continues to work on a State Plan Amendment related to lead, submitting responses to CMS questions on that state plan amendment. The Department is hopeful that it can implement this project before the end of the fiscal year.

- The Department will be releasing out significant regulation changes for HealthChoice that align with the federal managed care regulations. These changes are occurring to remain in compliance with the newly updated Medicaid and CHIP Managed Care Final Rule. The Department is updating Code of Maryland Regulations (COMAR) as well as the MCO agreements for 2018 to meet the federal requirements effective in 2018. MCOs will receive the agreements at their departmental meeting before the Joint Committee on Administrative, Executive, and Legislative Review (AELR) process. It will include all of the changes that have to take effect January 1, 2018.

- The Department is working on a State Plan Amendment for the Justice-Involved Presumptive Eligibility—anticipated for implementation on July 1, 2017—as well as the pharmacy reimbursement regulations and related State Plan Amendment.

- On April 1, 2017, the Department will apply new pharmacy pricing methodology, based on actual acquisition costs. This was part of a requirement from CMS to use the National Average Drug Acquisition Cost (NADAC) pricing guidelines.

- The Department presented on the status of the draft HealthChoice evaluation, which is due on April 21, 2017, asking for comments from the committee.

Maryland's legislative session began on January 11, 2017, concluding after the end of the quarter. For more information on legislative activity, please see the Legislative Update section.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women--currently, those women at less than 200 percent of the Federal Poverty Level (FPL). The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments

for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. Enrollment as of the end of the third quarter was 9,470 women, a decrease of 2.6 percent. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

REM Program

The table below shows the status of REM program enrollment.

Table 2. Current REM Program Enrollment

FY 2017	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	223	177	104	105	4,314
Quarter 2	212	159	85	104	4,344
Quarter 3	189	149	62	98	4,365

Reasons for disenrollment/discharge from REM include aging out of the REM qualifying diagnosis, loss of HealthChoice eligibility, loss of medical assistance eligibility, death, or a request to return to the MCO.

Table 3. REM Complaints

FY17 Q3	Transportation	Dental	DMS/DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	6	0	0
REM Hotline	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	6	0	0

The following table displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information on a monthly basis.

Table 4. REM Significant Events Reported by Case Managers

FY 2017 Q3	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	4	13	0	52	16	13	9	107

ICS Program

Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of the end of this quarter, there were 26 individuals enrolled in the ICS Program.

MCHP and MCHP Premium Status/Update/Projections

Effective June 1, 2008, Maryland moved its separate CHIP program, Maryland Children's Health Program (MCHP) Premium, into the Medicaid expansion CHIP waiver, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of March 31, 2017, the Premium program had 30,903 enrollees, with MCHP at 114,370 enrollees.

Expenditure Containment Initiatives

HealthChoice Financial Monitoring Report (HFMR)

Final 2015 HFMR MCO submissions were updated and reviewed. Unadjusted consolidated 2015 HFMRs by region were provided to all MCOs on March 21, 2017.

The final reviewed 2015 submissions will be the base period for the 2018 HealthChoice rate-setting period. The firm Myers & Stauffer is currently in the process of performing independent reviews of each MCO's submission which are due May 1, 2017. A separate actuarial firm is completing draft analyses of each MCO's IBNR estimates.

During the next quarter, all MCOs will submit their first HFMR reports for 2016 (reported as of March 31, 2017). These reports are due to the Department by May 15, 2017. MCOs were provided on March 9, 2017 with updated financial templates and instructions for completing their May submissions.

MCO Rates

The rate-setting team is based out of the Hilltop Institute, which provides technical support and program assistance to the Department. They performed the following activities in support of the CY 2018 HealthChoice rates:

- Provided Myers & Stauffer and the Department with "working" 2015 HealthChoice HFMRs and MCO financial reconciliation files for all eight MCOs
- Provided the Department with initial statistics on the recent FDA approved drug Spinraza. Spinraza is an injection administered into the fluid surrounding the spinal cord for the treatment of adults and children with spinal muscular atrophy (SMA). Estimates for Year 1 therapy costs range from $750,000 to $1 million. Annual Year 2 therapy costs are $375,000. Using specific ICD-10 codes, the initial CY 2016 experience identified 128 HealthChoice recipients; however, 73 of those 128 recipients were identified with one specific physician.
- The first 2018 HealthChoice MCO rate setting meeting was held on February 24, 2017. Main topics discussed were the goals, organization, and methodology of HealthChoice

rate setting, and the presentation of departmental issues. Next meeting currently scheduled for March 30, 2017.

- During the month of February, Hilltop provided Myers & Stauffer and the Department with three revised MCO "working" 2015 HealthChoice HFMRs and financial reconciliation files.
- Hosted planning conference call on February 7, 2017 with the Department, the Health Services Cost Review Commission (HSCRC), and Optumas, an actuarial firm, to discuss timelines for information needed from hospital regulator in the development of 2017 mid-year and 2018 HealthChoice rates.
- Co-facilitated second 2018 HealthChoice MCO rate setting meeting held on March 30, 2017. Topics discussed included: status of Myers & Stauffer review, discussion of DHMH and MCO issues, constant cohort analysis for CY 2015-2016 (as of February 28, 2017), and calculation of rate adjustment impact of change in contraceptive dispensing from 30 days to six months.
- Provided MCOs with current consolidated 2015 HealthChoice submission.
- Provided MCOs with templates to use for first CY 2016 financial submission for the HealthChoice program (HFMR).
- Incorporated revised 2015 HFMR submissions provided by MCOs. Individual MCO exit conferences and draft MCO reports for Myers & Stauffer due in the next two weeks.
- Provided DHMH with draft framework for new "blockbuster" drug policy for incorporation into the HealthChoice MCO program.

The rate setting team performed the following activities in support of the CY 2017 HealthChoice rates:

- Reviewed December 2016 prospective payments (the new 2017 HealthChoice rates implemented) for January 2017 MCO services as recorded on the MCO capitation file. All rate cells appear to have been implemented correctly.
- In conjunction with Optumas, provided the Department with "round three" responses to CMS questions regarding 2017 HealthChoice original certification.
- Provided the Department (to be forwarded to CMS) with technical narrative supporting the MD COMAR minimum medical loss ratio (MLR) calculation.
- Conference call was held with the Department and Optumas to discuss actuarial soundness and MCO payments below the rate range.

The rate setting team performed the following activities in support of the CY 2016 HealthChoice rates:

- Hosted meeting with one MCO on March 21, 2017 to discuss their 2016 and current 2017 financials.
- Provided specific MCO with own encounters incurred in CY 2016 through MMIS process.
- Provided the Department with analysis of MCO underwriting results for 2016.
- Provided each MCO with their draft 2016 ACA Health Insurance Fee settlement calculations for their review and approval.

The rate setting team also performed the following activities this quarter in addition to activities associated with HealthChoice capitation rates:

- Provided DHMH with trauma calculations for December 2016.
- Participated and attended nursing home liaison meeting held January 25, 2017.
- In conjunction with Johns Hopkins University, provided the Department with results of successful independent testing to replicate Hilltop's CY 2015 ACG assignments.
- Provided the Department with trauma calculations for January 2017.
- Attended and participated in nursing home liaison meeting held February 22, 2017.
- Provided the Department with alternative Value-Based Purchasing MCO payment methodology that is overall revenue-neutral. Conference call was held with the Department to formally present the methodology and to answer questions. Also provided the Department with the results of proposed payment methodology for two (CY 2013 & CY 2014) additional years.
- Provided the Department with five years of actual Medicaid Assistance experience by major category of aid as well as total and federal funding projections. This data format will allow the State to model the financial impact of possible future changes in federal reimbursement actions.
- Provided the Department with trauma calculations for February 2017.
- Provided the Department with revised Medicaid funding projections run out through FY 2027 and trended from FY 2020, using the three year equally weighted medical CPI of 3.2 percent.

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs). A budget neutrality worksheet is attached to this report.

Member Month Reporting

Tables 5 and 6 display the number of member months for the current quarter by eligibility group. The corresponding figure from the last month of the previous quarter is provided for comparison.

Table 5. Member Month Reporting

Eligibility Group	Total for Previous Quarter (ending December 2016)	Current Quarter Month 1 (January 2017)	Current Quarter Month 2 (February 2017)	Current Quarter Month 3 (March 2017)	Total for Quarter Ending March 31, 2017
Parent/Caretaker Relatives <116% FPL and Former Foster Care	623,410	210,609	212,040	213,674	636,323
ACA Expansion Adults	857,676	295,352	299,644	302,629	897,625

Eligibility Group	Total for Previous Quarter (ending December 2016)	Current Quarter Month 1 (January 2017)	Current Quarter Month 2 (February 2017)	Current Quarter Month 3 (March 2017)	Total for Quarter Ending March 31, 2017
Medicaid Children	1,337,183	451,785	454,647	458,344	1,364,776
SSI/BD Adults	267,510	88,880	88,712	88,846	266,438
Medically-Needy Adults	67,398	22,291	22,352	22,218	66,861
Medically-Needy Children	16,261	5,439	5,493	5,605	16,537
SOBRA Adults	27,364	9,321	9,419	9,432	28,172
MCHP	341,827	113,623	113,951	114,370	341,944
MCHP Premium	93,139	30,046	30,418	30,903	91,367
Family Planning	29,330	9,564	9,529	9,470	28,563
WBCCTP	469	150	149	146	445
PEPW	14	6	8	5	19

Table 6. Member Month Reporting for New Programs (For Informational Purposes Only)

Eligibility Group	Total for Previous Quarter (ending December 2016)	Current Quarter Month 1 (January 2017)	Current Quarter Month 2 (February 2017)	Current Quarter Month 3 (March 2017)	Total for Quarter Ending March 31, 2017
ICS	75	26	26	26	78
Home Visiting Pilot*	N/A	N/A	N/A	N/A	N/A
ACIS Pilot*	N/A	N/A	N/A	N/A	N/A

** The Home-Visiting and ACIS Pilots were still in the approval process as of the end of the quarter.*

Consumer Issues

The HealthChoice Help Line is the front end of the State's mandated central complaint program. The Help Line assists waiver eligible consumers with eligibility, enrollment, and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services—services not covered by the MCO but covered by Medicaid. When a consumer is experiencing medically-related issues such as difficulty getting appointment with a specialist, getting a prescription filled or getting a service preauthorized, the call is classified as a complaint.

Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who has the ability to

meet with the member face-to-face. If the MCO has issued a denial letter to the member and the member wishes to appeal the decision through the States Fair Hearing process, the CRU will assist the member with that process.

Including members not yet enrolled in MCOs, HealthChoice Help Line calls totaled 61,629, compared with 53,511 in the previous quarter—an increase of 8,118. MCO enrollment inquiry contributed to 20 percent of the increase in calls, which is typical during and after the open enrollment period for Qualified Health Plans.

Table 7. Total Recipient Complaints (not including billing) - 913 compared to 944 in the previous quarter (All ages enrolled in MCOs)

MCO	Amerigroup		Jai		Kaiser		Maryland Physicians Care		MedStar		Priority Partners		United Healthcare		University of Maryland Health Partners		Sub Totals	
Quarter	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Pharmacy 292/314	21%	29%	2%	0%	4%	6%	18%	20%	9%	10%	22%	17%	20%	16%	5%	2%	26%	28%
PCP 163/147	20%	26%	5%	3%	17%	12%	17%	10%	12%	10%	9%	16%	15%	17%	5%	5%	14%	13%
Specialist 148/139	22%	17%	3%	5%	8%	7%	16%	17%	16%	12%	11%	14%	19%	20%	5%	8%	13%	12%
Prenatal 89/87	16%	18%	3%	1%	24%	10%	9%	13%	11%	18%	17%	14%	16%	17%	4%	8%	8%	8%
Pharmacy/ CMC 32/27	13%	11%	6%	7%	0%	4%	9%	19%	3%	7%	25%	15%	41%	33%	3%	4%	3%	2%
DMS/DME 30/19	37%	32%	0%	0%	3%	0%	30%	37%	3%	11%	10%	16%	7%	0%	10%	5%	3%	2%
Laboratory /Tests 18/10	13%	11%	6%	7%	0%	4%	9%	19%	3%	7%	25%	15%	41%	33%	3%	4%	2%	1%
Pain Management 14/13	57%	23%	0%	0%	0%	8%	7%	8%	14%	31%	0%	15%	14%	15%	7%	0%	1%	1%

**Other categories-158/157*

The top three member complaint categories were pharmacy (28 percent), access to primary care providers (PCPs) (13 percent), and access to specialists (12 percent). These accounted for 53 percent of all member complaints. There was no significant change in recipient complaints by MCO. Amerigroup continues to have the highest percent of complaints related to pharmacy, PCP, prenatal, and durable medical supplies and equipment (DMS/DME).

Of the total 1,139 MCO recipient complaints, 112 were from pregnant women. Any woman who self-identifies to the Help Line as pregnant is referred to the Medicaid funded administrative care coordinator (ACC) in her county of residence. Another 168 women enrolled in MCOs also called the Help Line for general information and were subsequently referred to the ACC.

Table 8. Recipient Complaints under age 21 (not including billing) – 177 (19%) of total compared to 145 (15%) in previous quarter

MCO	ACC	JAI	KP	MPC	MS	PP	UHC	UMHP	Sub Totals

Quarter	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Pharmacy	8%	8%	6%	6%	1%	1%	23%	23%	20%	20%	3%	3%	21%	21%	17%	17%	34%	48%
PCP	13%	13%	13%	13%	4%	4%	16%	16%	12%	12%	1%	1%	20%	20%	18%	18%	37%	29%
Specialist	14%	21%	7%	4%	14%	4%	10%	21%	10%	7%	7%	11%	31%	21%	7%	11%	20%	16%
DMS/DME	43%	40%	0%	0%	0%	0%	14%	20%	14%	0%	0%	40%	29%	0%	0%	0%	5%	3%
Pharmacy/CMC	13%	13%	15%	15%	4%	4%	21%	21%	15%	15%	1%	1%	19%	19%	12%	12%	0%	1%
Laboratory/Tests	13%	13%	15%	15%	4%	4%	21%	21%	15%	15%	1%	1%	19%	19%	12%	12%	0%	1%
Vision	0%	100%	0%	0%	0%	0%	67%	0%	0%	0%	33%	0%	0%	0%	0%	0%	2%	1%

There was slight increase in complaints from individuals under age 21. The top three complaint categories for children were the same as for adults: pharmacy (48 percent), access to PCPs (29 percent), and access to specialists (16 percent). Pharmacy complaints in the under 21 population increased by 14 percent. Some drug access issues are drugs covered by the State and not the MCO. Three MCOs (ACC, MPC, PP) had an increase in the percent complaints related to access to specialists.

Table 9. Total Recipient Billing Complaints: – 226 (20%) compared to 190 (17%) in the previous quarter

MCO	ACC		JAI		KP		MPC		MS		PP		UHC		UMHP		Sub Totals	
Quarter	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Specialist 72/106	24%	22%	0%	0%	10%	8%	19%	15%	8%	8%	11%	26%	25%	14%	3%	6%	38%	47%
Emergency 59/72	27%	24%	0%	0%	14%	15%	27%	19%	10%	4%	17%	28%	3%	7%	2%	3%	31%	32%
PCP 33/29	15%	28%	0%	3%	9%	10%	6%	10%	15%	3%	33%	21%	21%	17%	0%	7%	17%	13%
Laboratory / Tests 26/18	15%	6%	0%	0%	12%	0%	12%	22%	0%	22%	33%	28%	23%	17%	4%	6%	14%	8%
Pharmacy 0/1	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

The State also investigates consumer billing complaints. Billing complaints increase during the reporting period, largely representing inappropriate billing of MCO members by specialists. The top three bill types for consumers in were unchanged. During the third quarter, specialists accounted for 47 percent of billing complaints, emergency services for 32 percent, and primary care physicians for 13 percent. Priority Partners has the highest.

MCOs are required to respond to all complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the ACC for follow-up to ensure the complaint has been resolved.

When trends are identified, an inquiry is made to the MCO by the HealthChoice Medical Advisor. If potential policy or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2017 session commenced on Wednesday, January 11. Some of the major bills that have been introduced that would affect the State's Medicaid program are as follows:

- **HB152 (Budget Reconciliation & Financing Act of 2017)** - Makes changes to the State's budgeted Medicaid deficit assessment and places restrictions on changes to the program's eligibility and benefits rules
- **SB476/HB580 (Keep The Door Open Act)** and **SB967/HB1329 (Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017)** - Requires rate increases for community behavioral health providers and implementation of a new rate-setting system for community providers
- **SB415/HB631 (Public Health - Essential Off-Patent or Generic Drugs - Price Gouging - Prohibition)** - Seeks to prohibit price gouging by manufacturers and distributors of 'essential' off-patent or generic drugs
- **SB1109/HB1599 (Nursing Homes - Partial Payment for Services Provided)** - Requires the State to make advance payments to nursing homes for uncompensated program services provided to residents who filed an application for Medicaid services, but eligibility was not determined within 90 days
- **HB444 (Public Health - Participation in Healthy Lifestyle Programs - Incentives & Tax Credits)** - Authorizes financial incentives to promote participation in a healthy lifestyle program by MCO enrollees
- **HB458/SB604 (Visual Impairments - Requirements for Teacher Training, Student Screening & Maryland Medical Assistance Program Coverage)** - Requires Medicaid coverage for vision rehabilitation and habilitation for individuals below 133% of poverty
- **HB847 (Maryland Medical Assistance Program - Benefits for Individuals Who Are Incarcerated or Institutionalized)** - Requires six months presumptive eligibility for individuals on release from incarceration or from an IMD
- **HB1158 (Maryland Medical Assistance Program - Comprehensive Dental Benefits for Adults - Authorization)** - Requires coverage of comprehensive dental services for adults below 133% of poverty beginning January 1, 2019
- **SB169 (Health - Cost of Emergency Room Visits to Treat Dental Conditions & Coverage of Dental Services Under Medicaid - Study)** - Authorized Maryland Dental Action Coalition to conduct a study to determine the annual cost of emergency room visits to treat dental conditions of adult Medicaid enrollees, adults with private insurance and uninsured adults, and whether it is 'advisable' to include dental services for Medicaid enrollees who are adults with incomes below 133 percent of poverty; Medicaid is authorized to provide coverage of dental services for adults below 133 percent of poverty if the report finds that it is advisable
- **SB363/HB613 (Pharmacists - Contraceptives - Prescribing & Dispensing)** - Requires Medicaid and Maryland Children's Health Program to provide coverage for services rendered by a licensed pharmacist to the same extent as services provided by any other licensed practitioner for screening and prescribing contraceptives for enrollees
- **SB877/HB1347 (Maryland No Fault Birth Injury Fund)** - Establishes a system for adjudication and compensation of claims arising from birth-related neurological injuries, with a fund that is capitalized by premiums from hospitals and obstetrical physicians

- **SB903 (Health & Aging Programs - Establishment & Funding Requirements) -** Establishes administrative care coordination unit program to provide funding to local health departments to provide outreach, education and care coordination services for Medicaid enrollees and uninsured/under-insured individuals
- **SB984/HB1233 (Maryland Medical Assistance Program - Enhanced Security Compassionate Release Program) -** Requires the State to apply to CMS for a waiver by October 1, 2017 to establish a program (capped at 500 enrollees) to provide services to individuals in State correctional facilities to need skilled nursing care and were released 'as if on parole' because they are terminally-ill or mentally-incapacitated

The last day of the 2017 session will be Monday, April 10. An update on final action on Medicaid-related legislation will be provided in the upcoming quarterly report.

Quality Assurance/Monitoring Activity

Quality Assurance Monitoring

The Division of HealthChoice Quality Assurance (DHQA) monitors HealthChoice MCOs quality assurance activities in accordance with the COMAR 10.09.65.

Systems Performance Review (SPR)

The first Interim Desktop reviews were completed. The preliminary findings were posted to each MCO port site. The department is currently working with the External Quality Review Organization (EQRO) in reviewing the final reports.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

The CY 2017 EPSDT Orientation manual was posted to the MCO Resource Sites. The EQRO reviewed the medical record data sample from Hilltop to ensure completeness.

Value-Based Purchasing (VBP)

The CY 2015 Final VBP Report was posted to the MCO Resource sites and the Department HealthChoice website.

Consumer Report Card

CY 2017 Consumer Report Card was finalized and posted to the MCO Resource sites. A higher resolution version was provided to the enrollment broker to be printed and included in the 2017 new enrollee packages.

Performance Improvement Projects (PIP)

The EQRO validated Adolescent Well Care (AWC) and Controlling High Blood Pressure (CBP) PIP Submissions and posted to the portal for the Department's review and approval. The PIP evaluation is based on each MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) scores. The final AWC report was posted to the MCO Resource Sites. The PIP Annual Report was also posted to the MCO Resource Site. The EQRO also finalized the Asthma Medication Ratio (AMR) PIP Submission Form and Instruction Sheet and posted to the MCO Resource Sites.

Annual Technical Report (ATR)
The EQRO and the Department continued work on the CY 2016 ATR. This report will include all quality assurance activities for CY 2015 in which conclusions were drawn as to the timeliness, quality, and access to the care provided by all eight MCOs for the Maryland HealthChoice program. This report will be submitted to CMS by April 30, 2017.

HEDIS Performance Review
The Department's new HEDIS vendor reviewed the 2017 Consumer Assessment for Health Providers and Systems (CAHPS) Sample frame submitted by the Hilltop Institute and gave final approval for use in processing the CAHPS surveys. All MCOs submitted the required HEDIS Roadmap submission by end of January. In February, the National Committee for Quality Assurance (NCQA) released the proposed new measures and changes to existing measures for HEDIS 2018 for public comment. One change of note is that NCQA is seeking comments on proposed changes for the Plan All-Cause Readmissions measure specific to the Medicaid population for inclusion in the HEDIS 2018 measurement set. The public comment period ended in mid-March.

The HEDIS vendor conducted onsite audits in February and March and provided post onsite audit remarks reports from each HealthChoice organization. Also in February, the vendor requested the Department's assistance with addressing a problem with public health's ImmuNet registry. The Registry needs to be adjusted to accurately reflect the Tdap vaccination, as the HEDIS measure specifications have been altered and no longer allow Td vaccinations to count towards numerator compliance. The vendor discussed the audit and reporting timeline and potential changes for HEDIS 2018 at the Quarterly Quality Assurance Liaison Committee (QALC) meeting was held in March.

HealthChoice Enrollee Satisfaction Survey
In January, the Department and NCQA approved the questionnaires and collateral materials for the 2017 HealthChoice Enrollee Satisfaction Survey. The first questionnaires were mailed in mid-February. Survey fielding continued through March with the processing of returned, completed surveys and the mailing of the second questionnaires and postcard reminders. The Department hosted a pre-proposal conference in March for all NCQA-Certified CAHPS survey vendors interested in potentially bidding on the new Satisfaction Surveys Contract beginning in October 2017. The Request for Proposal (RFP) for this contract was listed on the eMaryland Marketplace website through mid-April.

Provider Satisfaction Survey
Also in January, the Department approved the questionnaire and collateral materials for the 2017 Provider Survey. To increase the response rate from primary care providers, the survey tool continues to include an option for the provider to complete the survey online. The final Provider Sample Frames were obtained from the MCOs in late January. In February and March, the sample frames were de-duplicated and the first questionnaires were mailed. Survey fielding continued through March with the processing of returned, completed surveys and the mailing of postcard reminders.

Demonstration Evaluation

The Department is currently in the process of designing the draft Summative Evaluation; it is due on April 21, 2017.

The Department has also scheduled a post-award forum. It will be held on June 22, 2017.

Enclosures/Attachments

Maryland Budget Neutrality Report as of March 31, 2017

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